



**CORE CURRICULUM
IN
PSYCHIATRY
FOR
MEDICAL STUDENTS**

**WORLD PSYCHIATRIC
ASSOCIATION**

**WORLD FEDERATION FOR
MEDICAL EDUCATION**

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Message from the World Psychiatric Association

Professor Norman Sartorius, M.D., Ph.D.
President, World Psychiatric Association

Activities of major international organizations are usually timed independently which makes collaboration between organizations in the implementation of such activities difficult and their products overlapping, sometimes contradictory and often deficient in parts that are at the border of their mandatory functions. The coincidence of the major effort of the World Federation for Medical Education to revive and revise the medical education and the increase in emphasis that the World Psychiatric Association gives to psychiatric education at undergraduate and postgraduate levels was not planned; that it occurred is however fortunate for both organizations.

The collaboration of the World Psychiatric Association with the World Federation for Medical Education is a development that may be the beginning of a new era in

psychiatric education worldwide. The gap that existed between psychiatry and the rest of medicine has been detrimental to the development of medicine and psychiatry. Bridging it can not be done at once: there are too many prejudices and traditions that bar the way. If the ambitions of the programme presented here can be fulfilled we may be able to soon greet a new generation of doctors--a new generation that will see psychiatry in its true light, recognize the importance of adequate training in psychiatry and accept to collaborate in the development of programs of health research, training and service in which psychiatry will have its rightful place and in which patients and their communities will be able to benefit from the knowledge and insights that psychiatry as a discipline can contribute to the betterment of medicine in theory and practice.

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Foreword

Professor Henry J. Walton, M.D.
Immediate Past-President, World Federation for Medical Education
University of Edinburgh

What every doctor in the world should know about psychiatry

This document is of most immediate concern to all teachers of psychiatry, and calls on them to reconsider what they teach.

A consequence of the great tide of reform now occurring worldwide in medical education is that particular attention is being paid to *The New Medicine*. By this phrase medical teachers imply that concentration on curative medicine is no longer enough. Curricula now have to focus also on prevention of illness and promotion of health given only marginal recognition in conventional curricula. These critical dimensions have been endorsed in recent years by the two major reforming developments in medical education (World Federation for Medical Education, 1988 & 1993).

The publication of **A Core Curriculum in Psychiatry** is therefore immensely important, for two quite different reasons, one specific and the other general. The document in the first place is a landmark in education of psychiatrists, but it has the wider significance also of reflecting the clinical policy now necessary for the actual practice of medicine. The document thus has a dual thrust, directed primarily at the teaching of psychiatry, and more generally at health service delivery i.e. clinical policy. In both spheres promotive and preventive medicine has emerged from the sidelines to become a major priority.

No reader of this document will be left unaware of the vast extent of psychiatric morbidity, the burden on people,

communities and nations of mental illness. Definition of a global core curriculum, setting out the specific competence in psychiatry to be taught to all doctors, is an immensely ambitious undertaking signifying that all future doctors should be educated and trained for specific competence.

The World Psychiatric Association and the World Federation for Medical Education have collaborated to define the **Core Curriculum in Psychiatry**, for equipping all future doctors to identify and treat mental illness and disability.

The **Core Curriculum** serves a second, very general and urgently necessary function. It serves as a case study for the whole of medical education, indicating how the entire body of training of the health professions should be rethought. It points out the perspective without which *The New Medicine* will be no more than a figment. The **Core Curriculum** stands as an example to all branches of medicine, requiring as it does that teachers in every specialty must examine their own curricula, to identify the preventive and promotive aspect of their teaching. The **Core Curriculum** is thus an object lesson for medicine in its entirety.

The World Conference on Medical Education, held in Edinburgh in 1988, concluded with the *Edinburgh Declaration* (World Federation for Medical Education, 1988). Twelve principles were set out, the third calling for an emphasis in curricula to be on disease prevention and health promotion. This large demand is still not recognized for the major innovation it represents. Often refuge is still taken behind pious disclaimers, that not enough is known about preventive or promotive considerations, for either to feature in curricula. Medicine, the most common evasion runs, has been brought into disrepute by health promotion advice which is flimsy in its basis, and hence has a brief shelf-life - only irritating confused members of the public - and lacks the conviction conferred by hard scientific evidence. Mainstream medical teachers are as reluctant to advocate health promotion, it seemed, as they were to teach in settings away from the main tertiary care teaching hospital.

WFME therefore instituted the *Global Curricula Project*, designating six key specialties in which the importance of health promotion was inarguable: public health, general practice, paediatrics, otorhinolaryngology, psychiatry and neurology (World Federation in Neurology, 1994). The implication was that specialties had to redefine their entire curricular, to give proper scope to the preventive and promotive aspects of the contribution made by the specialty to the training of future doctors.

The corresponding world body of each of these specialties was mobilized as a partner with WFME in the global endeavor. The World Federation of Neurology, for example, in partnership with WFME, at a joint international conference called in London in 1993 did recast the *Edinburgh Declaration* entirely in the neurological context. The collaboration with the World

Psychiatric Association enabled the international Core Curriculum Committee to bring forward proposals to the 10th World Congress of Psychiatry in 1996 in Madrid. The *Global Curriculum Project in Psychiatry* was the focus of a Presidential Workshop, chaired by Professor Felice Lieh Mak, when a draft core curriculum was presented for debate to international participants: academics, service providers and policy makers. At this international forum special consideration was given to requirements for implementing change in teaching and learning. A major consideration was governance of the medical school: the changes in administration, committee structure, resource allocation and designated authority without which curricular reform in teaching of a subject like psychiatry will not be achieved.

While the validity of the *Edinburgh Declaration* remains uncontested as a global mandate for reform of medical education, massive social, political, economic and managerial changes worldwide are impacting in major ways on medical schools. The 1993 *World Summit on Medical Education* (WFME 1994) again in Edinburgh, was entitled *The Changing Medical Profession*, precisely so that the redefinition of medical doctors now taking place should not be in any possible doubt.

Implementation of the *Summit Recommendations* has been explored at six Regional Conferences during 1994-5. Every region explored intensively, in the local context, the paramount requirement that medical education imperatively demands a close relationship between the health care system and the medical education system in every country. To achieve such harmonization, all of the WFME Regional Conferences called for the conjoint setting up of authoritative and resourced health councils, to link Ministries of Education and of Health, the medical

schools, and professional bodies (WFME 1995). The **Core Curriculum** presented in this document will need the sanction of national government for its full implementation.

The major reforms promoted by this document warrant just such high level collaborative action, with utmost urgency, so that future doctors in all countries will be equipped to meet the mental health needs of people and communities throughout the world.



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Introduction

The need for psychiatry in the medical curriculum

That psychiatry should occupy a major part in the medical curriculum is now generally agreed. There are three reasons for this agreement. First, the general approach of psychiatry which stresses the unity of body and mind is important in the whole of medical practice. Secondly, skills that are learned in psychiatry are important for all doctors: for example the ability to form a good relationship with a patient, to assess the mental state, and to impart distressing information. Thirdly psychiatric problems are common among patients seen by doctors working in all branches of medicine: for example it is known that among outpatients attending specialist clinics about 15 per cent of those given a diagnosis have an associated psychiatric disorder, and an average of 20-30 per cent of those given no medical diagnosis have a psychiatric disorder. Psychiatric disorders are even more frequent among patients attending general practice. Therefore, all future doctors must know about these psychiatric problems not only because they are common, but also because their management involves much medical time and resources, and gives rise to many serious incidents.

Psychiatry in the medical curriculum

- Psychiatry's generalized approach stresses the unity of body and mind.
- Skills learned in psychiatry are useful to all medical practitioners.
- Psychiatric problems are common among patients seen by doctors working in all branches of medicine.

The proposed curriculum

The core component in psychiatry in the curriculum described in this Report is the minimum that is required by medical students who, after qualification, will enter further training whether they are to work as specialists or in primary care. In many countries doctors who have chosen a career in primary care (general practice) receive a further period of training after graduation, and in most of these countries this training extends their psychiatric skills. In countries with no formal training for primary care doctors (general practitioners), the teaching in psychiatry described in this report needs to be supplemented by a module containing the additional material that is essential for management of the psychiatric morbidity encountered in general practice. This module will need to be developed locally to take account of the special circumstances of practice in the country.

The educational objectives of the proposed core curriculum are described under the generally accepted headings of the attitudes, knowledge and skills which need to be acquired by students, with a note on the place of sciences related to psychiatry. Further sections deal with methods of teaching and learning and methods of assessment. Throughout the emphasis is on a teaching process in which the student is given an active role.

This Report describes the minimum requirements in psychiatry for medical students who will enter further training whether they are to work as specialists or in primary care.

Attitude objectives

Since most students will not enter psychiatry, the acquisition of appropriate attitudes is of primary importance. It is important that the objective of imparting these attitudes is in the teachers mind throughout his interaction with students. Most of the attitudes to be acquired while learning psychiatry do not differ from those needed to practise the rest of medicine. The extent to which these attitudes are emphasised to students in the psychiatry programme, rather than during the periods for other subjects, will vary from one medical school to another. However, each school should have a clear plan that ensures that the necessary attitudes have

been acquired by the time the students graduate. It is important that students develop appropriate attitudes to psychiatry as a medical discipline. These attitudes will be encouraged particularly during the teaching of psychiatry but it is important that they are not negated during the teaching of other subjects.

It is important that attitudes are not merely expressed verbally by students but are also internalised, directing how students respond to patients and their colleagues. Each of the attitudes listed below should be translated into corresponding action.

<i>Attitudes concerned with medical practice generally</i>	<i>Attitudes towards patients and their families</i>	<i>Attitudes to psychiatry as a medical discipline</i>
<p>Students should:</p> <ul style="list-style-type: none"> ◇ Recognise that the profession of medicine requires lifelong learning. ◇ Show capacity for critical thinking and constructive self-criticism. ◇ Be able to tolerate uncertainty and be open-minded to the views of others. ◇ Be able to work constructively with other health professionals. 	<p>Students should:</p> <ul style="list-style-type: none"> ◇ Respect patients and understand their feelings. ◇ Recognise the necessity of good doctor patient relationships. ◇ Appreciate the value of the developmental approach to clinical problems emphasising the stages of the life cycle and longitudinal perspective of illness. ◇ Recognise the importance of the family and the wider environment of the patient. 	<p>Students should:</p> <ul style="list-style-type: none"> ◇ Recognise the value of psychiatry as a medical discipline. ◇ Integrate humanistic, scientific and technological aspects of knowledge of psychiatry. ◇ Recognise the importance of the promotion of mental health and the prevention of psychiatric disorders.

Knowledge objectives

The knowledge objectives of psychiatry include psychiatric symptoms and syndromes, psychological aspects of medical disorders, (“psychological medicine”), and psychosocial issues including stigma. Psychiatric symptoms and syndromes, and their treatment, are to be taught and learned in the context of an integrated biological, psychological and social approach. Knowledge objectives can be formulated in broad terms or as a detailed curriculum. A detailed list may be important not only to guide teachers and students but also to indicate to the Deans and Curriculum Committee of the Medical School, the substantial factual basis of psychiatry and the resources needed to teach this.

Whatever level of detail is chosen concerning each individual disorder, collectively these should provide opportunities to:

- a) illustrate the approach to aetiology in psychiatry,
- b) provide opportunity for the discussion of attitude objectives and teaching of skills objectives,
- c) provide instruction concerning action that should be taken.

An example of a widely used curriculum is provided in *Appendices 2 and 3*, together with an example of the way in which items in the curriculum can be specified in more detail to guide students in their learning.

Skills objectives

The skills required by medical students range from those with which they need only be familiar (in the sense of being aware that they are practised by others, e.g. dynamic psychotherapy), to those skills which students are expected to perform competently themselves.

Many of the skills students learn in psychiatry overlap with those learnt in the other branches of medicine. The stage in the curriculum at which the various skills should be learnt is a matter for the curriculum committee of the medical school to decide.

Skills to be acquired

Doctor-patient interpersonal skills

They include the skills of:

- "active listening"
- empathy
- non-verbal communication
- opening, controlling and closing an interview

Information gathering skills

- Take the history of patient's complaints and a life history
- Carry out a physical examination, taught also in other parts of the curriculum.
- Also includes skills necessary to assess the functioning of:
 - the patient's family and
 - the family's ability to contribute to the patients' care

Information evaluation skills

- Select the crucial pieces of information for making a diagnostic formulation and undertake a differential diagnosis
- Make a personality assessment
- Evaluate the role of personal and social factors in the patient's behaviour
- Formulate a plan of management which includes the points at which referral to a specialist will be appropriate.

Information-giving skills

- Pass information to patients to promote health
- Explain the implications of a diagnosis
- Inform patients about the beneficial and potential adverse effects of treatment

Reporting skills

- Report verbally or in writing to:
 - medical colleagues
 - lay people including the relatives of patients
 - non-medical agencies involved in the care of patients
- Promote public education

Treatment skills

- Promote compliance with prescribed treatment
- Basic prescribing skills for the psychiatric disorders commonly encountered by non psychiatrists.
- Recognise adverse effects of treatment and distinguish them from symptoms of illness

Learning skills

- Sustain self-directed independent learning such that the student will be able to keep abreast with new advances in psychiatry and psychological aspects of medical practice throughout professional life.

Teamwork skills

- Co-operate with:
 - medical colleagues
 - other health care workers
 - patient and family organizations
 - community services
 - the general public
- in arranging the care of patients with psychiatric problems and for promoting mental health.

The sciences related to psychiatry

Students are required to understand in general terms:

- A) The contribution of scientific research to psychiatric aetiology and treatment.
- B) Those aspects of the biological, psychological and social sciences which can increase understanding of these conditions and the way such factors interact.

Methods of teaching and learning

Independent and problem-based learning

Teaching and learning is concerned with fostering attitudes as well as with the acquisition of knowledge and skills. Students should be engaged as far as possible in self-directed independent learning which is problem-based. Case studies, role playing, work in groups, and the literature search concerning a specific clinical problem, can all help to foster independent learning. Other useful techniques include: visits to patients' homes and to their families, as well as experience of the care of emergencies. It is of course difficult to achieve small group teaching in medical schools in which there are large classes and small numbers of teaching staff. Nevertheless problem-based learning can be employed in large classes and a questioning approach encouraged among students even in cultures in which there is a tradition of unquestioning acceptance of the word of teachers.

Use of teaching aids

Discussion of video or audio tapes of interviews by teachers and by students are valuable, provided these are made locally. However, the teaching of psychiatry can be done well without expensive technology (which may be difficult to obtain and maintain in some developing countries). Teaching and learning should integrate students' clinical knowledge with their knowledge of the scientific basis of medicine. These teaching methods should be adapted to the culture of the society in which the medical school works and the system of health care in the country.

Guidelines for the teaching and learning of psychiatry

- Self-directed, problem-based learning
- Locally produced teaching aids
- Exposure to a range of patients in different settings
- Integrated psychiatric teaching and learning in the curriculum

General guidelines for the teaching of psychiatry

Students should see a range of patients including those typically managed in primary care, general hospitals, and community based clinics as well as those treated in psychiatric facilities. Teaching should be about problems of relevance to students likely future clinical experience and not focused on specialised practice of psychiatry. Patients from primary care may be more relevant to this aim than those in a psychiatric in or outpatient practice.

Psychiatry and the planning of the medical curriculum

Psychiatric teaching and learning needs to be consistent with that of the medical school curriculum as a whole. Psychiatrists therefore need to be involved in the planning of the overall medical curriculum as well as their own subject. They must gain the respect of the other medical teachers for psychiatry as a medical discipline and for patients with psychiatric conditions, and reduce the stigma that is often associated with psychiatry.

Assessment

Teaching methods should be evaluated by students, thus helping individual teachers to improve their performance and to upgrade the teaching programmes as a whole (see p.00).

A distinction is to be made between two types of assessment. *Formative* assessment

is designed to give feedback to the student about his progress as he proceeds. *Summative* assessment is carried out at the end of the courses for purposes of grading.

Both teachers and students should evaluate each course; the latter assessments are particularly valuable.

Assessment of knowledge

Knowledge can be assessed at three levels through various methods.

Knowledge level	Method of assessment
Recall of factual information	<ul style="list-style-type: none"> – Multiple choice questions – Short answer essays
Interpretation of data	<ul style="list-style-type: none"> – Short answer essays – Appropriately constructed MCQs – Essays
Problem-solving	<ul style="list-style-type: none"> – Patient management problems – Case reports – Group projects

Other innovative methods for assessing the interpretation of data include the requirement to write an assessment of a short scientific paper or a drug information leaflet. Assessment need not require complex technology to be effective.

Assessment of skills

So that students know what is expected of them, such skills have to be specified at one of the following three levels:

- i. Awareness or minimal familiarity
- ii. Capacity for performing a skill
- iii. Full competence

The usual method for assessing skills is the clinical examination and by continuous assessment made during the student's clinical clerkship. Innovative methods for assessing clinical skills include objective structured clinical examinations (OSCEs); and by the examiner playing the role of a patient, while the student is asked to demonstrate how he would deal with the problem presented.

Assessment of attitudes

Question and answer methods such as MCQ, or short answer questions, assess only factual knowledge. Assessment of attitudes requires observation of the student's behaviour in response to patients during the clinical aspects of the course, as well as assessment in the oral and clinical examinations. Continuous assessment is a particularly useful way of assessing attitudes, since views expressed in case discussions, seminars and tutorials can be taken into account. At some medical schools the opinions of patients have been sought as part of the assessment of a student's attitudes, and also the judgement of simulated patients when they feature in examinations.

Selection of students

Personal attributes

While it is common practice for applicants to medical school to be admitted on the basis only of academic achievement it is

now generally accepted that personal attributes relevant to clinical practice should be taken into account when students are selected including:

Attributes	Methods of assessment
Capacity to relate to others	Well planned interviews
Motivation for self-directed learning	Reliable references
Humanistic attitudes	Attention to biographical data

Psychiatrists should be involved along with other members of the teaching staff in the selection of applicants.

Other attributes

Medical schools have the obligation to make their intake criteria fair and valid. Greater reliability of selectors results when selection methods, such as interviews, are structured. All the interviewers have received training in selection procedures.

Medical schools should follow-up the outcome of their selection procedures.

Attributes to be assessed include:

- Ability to think critically
- Problem-solving ability
- Communication skills
- Ability to cope with stress
- Self-understanding

The training of teachers

It is important that teaching is recognised as an important activity within the medical school. Also the financial rewards for teaching should be commensurate with those for clinical work if teachers are to be encouraged and retained.

Teaching staff require to have an interest in teaching, and have to realise that they require to be trained for their role as teachers. It is thus important that account is taken of interest in teaching when staff are appointed. University departments should give high priority to teacher training, within

the medical school, so that staff have educational expertise as well as clinical and research competence. There should be an educational development programme, to extend all teachers' understanding of the teaching-learning process and update it regularly. Educational resources should be provided: educational resource persons, educational literature, and regular seminars and workshops. The teachers of psychiatry should participate in the educational committee in the medical school responsible for the curriculum as a whole.

Additional teaching for primary health care

In developed countries medical students graduate as generic doctors who can enter general practice only after further training. In other countries students can work in general practice as soon as they qualify fully without this additional training in general practice. In the latter countries medical students need to receive additional teaching in psychiatry during the medical student period, since psychiatric disorders form such a large part of the work of primary care doctors. This additional psychiatric training in developing countries should extend across the medical curriculum as a whole. It should also continue, after graduation, as part of in-service training and CME.

Knowledge, skills, and attitudes content

The teachers in the countries concerned will be able to decide the necessary content of this additional preparation for general

practice responsibility directly after qualification. In addition to the knowledge content, the skills needed to diagnose psychiatric problems within a system appropriate for primary care will be important, and also the skills needed for treatments used most often by general practitioners and the knowledge of when to refer to specialist services. Attitudes that will promote mental health and reduce stigma have also to be acquired. A substantial part of this additional teaching should take place in the community settings in which students are likely to work when qualified, and teamwork skills necessary for the doctor to do his work in conjunction with non-medical staff are critically important. The ICD classification for primary care is a useful guide to the additional teaching needed for primary care.

Behavioural science teaching

The term behavioural science teaching is used to refer to three separate issues. First to the scientific basis of psychiatry: this teaching is clearly the responsibility of the psychiatry department. Secondly the term refers to what is sometimes called medical psychology, namely training in sensitivity, interviewing and communication skills and in recognising the role of family and other social factors in illness. All these components are part of the medical

curriculum as a whole. The third use of the term refers to the scientific disciplines that are used to understand behaviour: these include not only psychology and sociology but also aspects of genetics, biochemistry and physiology that underlie the origins of complex behaviour. We have not included a syllabus for behavioural science teaching since this involves many other department than psychiatry.

Time and resources

It is an important responsibility of psychiatric teachers to convince the medical faculty of the value of psychiatry in the general medical curriculum. The case is made by:

- a) the frequency of psychiatric problems in the general practice of medicine
- b) the substantial factual basis of the subject
- c) the need to teach communication skills.

Time

When this importance has been accepted, the time needed to teach the subjects will follow. Exact figures about the amount of teaching hours that are required for the core curriculum depend in part on the amount of conjoined teaching with other departments, and the extent of teaching of communication skills during other parts of the medical curriculum. The amount of time spent in the psychiatry department will also depend on the other opportunities for

teaching behavioural science and psychosocial aspects of medicine in the curriculum as a whole. Corresponding resources need to be provided for this teaching.

In addition to this full time study two other periods of teaching are essential. First, opportunities to teach psychiatry are required during other clinical attachments, especially in medicine, surgery and general practice attachments. Secondly an adequate proportion of time allocated for lectures and seminars in the curriculum should be allocated to psychiatry and mental health issues. Such teaching should be scheduled at several times in the curriculum, selected by the Teaching and Learning Committee of the medical school, according to the opportunities available and the skills of the teachers.

With these provisos in mind, 8 weeks is required to teach psychiatry, though some of this teaching can be outside the single block of a psychiatry attachment though the latter should never be less than 4 weeks. Corresponding resources need to be allocated to provide adequate teaching and

learning during this period. The timing of the full time attachment within the course is generally best in the second clinical year provided that some additional time for

teaching is allocated in the first and third years.

Implementation

The implementation of this Report depends on the overall objectives of the medical school, and does not only concern the psychiatrists working within it. Each university hospital must have a psychiatric unit whose head is responsible to the dean

of the medical school for the teaching of psychiatry. It is his duty also to ensure that communication skills and the different aspects of psychological medicine are included appropriately in the medical curriculum.

Appendices

1. Summary of Survey
2. Specimen syllabus
3. Examples of student guidelines to the curriculum (selected topics)
4. Extracts from ICD10 PHC reference
5. References on methods of examination (including objective structured clinical examinations).
6. Annotated list of WHO publications relevant to the teaching of medical students.
7. Annotated Bibliography
8. Addresses

Appendix 1

Summary of Survey

To enable the Task Force to have some initial information to work on, Professor Moussauoi, Drs. Farid Bousaid and Imane Tazi were asked to conduct a survey of a random selection of medical schools with departments of psychiatry. The survey questionnaire was developed in the course of a WPA/WHO workshop on psychiatric education.

Issues which received support from the majority of respondents are listed here:

- The teaching of psychiatry should combine both theory and practice.
- The evaluation of students should incorporate clinical elements.
- Topics for inclusion in the curriculum
 - Psychiatric disorder
 - Psychopharmacology
 - Psychotherapy
 - Interviewing skills
 - Patient-doctor relationship
- The necessity of sensitising other specialities to the importance of psychiatry
- The need to highlight the importance of mental health in the community.
- The need to improve the teaching of behavioural sciences and psychotherapy.
- The need for a global co-ordinated effort in working for improvement in the teaching of psychiatry at an undergraduate level.

Appendix 2

Specimen syllabus

Syndromes

In presenting syndromes to students, it is appropriate to group them according to a simplified classification such as that used in the Primary Health Care Version of ICD10 (see *Appendix 4*). *Appendix 2* contains a specimen syllabus that lists subjects with a brief note of the aspects that are most

relevant. *Appendix 3* presents a more detailed student-centred syllabus. Each medical school should construct its own detailed syllabus covering the same topics but adapted to the needs of the local population.

Students are required to identify and understand:

Delirium and dementia	<ul style="list-style-type: none"> – Common causes – Principles of management of each syndrome
Misuse of and dependence on alcohol and drugs	<ul style="list-style-type: none"> – Diverse presentations – Complications – Outcomes of the conditions – Principles of prevention and treatment
Schizophrenia and related disorders (including acute and chronic delusional disorders)	<ul style="list-style-type: none"> – Recognition of disorders – Treatment of an acute episode – Principles of long-term management
Depressive and manic disorders	<ul style="list-style-type: none"> – Recognition of mania and depressive disorders of all degrees of severity – Co-morbidity of depressive and other disorders – Treatment of uncomplicated cases
Acute reactions to stress, PTSD, and adjustment disorders (including reactions to terminal illness and normal and abnormal grief)	<ul style="list-style-type: none"> – Recognition of these conditions – Management of uncomplicated cases
Anxiety, phobic and obsessional disorders	<ul style="list-style-type: none"> – Recognition of disorders – Treatment of uncomplicated anxiety and obsessional disorders
Somatoform disorders	<ul style="list-style-type: none"> – How physical symptoms arise without physical pathology – Concepts of conversion disorders – Hypochondriasis – Somatoform disorders – Principles of management
Disorders of eating, sleeping, psychosexual functions	<ul style="list-style-type: none"> – Clinical presentations – Principles of management of uncomplicated cases
Personality disorders	<ul style="list-style-type: none"> – Concepts of personality and personality disorders – Influence on physical and mental illnesses
Mental retardation	<ul style="list-style-type: none"> – Principles of prevention – Recognition of the most common syndromes – Principles of management

Childhood psychiatric disorders	<ul style="list-style-type: none"> – Common psychiatric disorders of childhood and adolescence – Principles of management
Old age psychiatric disorders	<ul style="list-style-type: none"> – Impact of ageing on health and psychiatric illness – Recognition and principles of management of psychiatric disorders in the elderly
Suicide	<ul style="list-style-type: none"> – Assessment of risk – Management of potentially suicidal patients and of those recovering from self-harm
Other syndromes	<ul style="list-style-type: none"> – Dangerousness and the management of potentially violent people – Physical abuse of children and adults

Treatment

Students are required to understand:

Main groups of psychotropic medications	<ul style="list-style-type: none"> – Indications – Contraindications – Major side effects – Interactions – Toxic effects – Other adverse effects <p><i>Students should also be able to impart information about and ensure compliance with medication.</i></p>
Principal methods of psychological treatment	<ul style="list-style-type: none"> – General nature and purpose of individual and group dynamic psychotherapies and counselling. – Simple counselling techniques
Principles of social treatment and rehabilitation	<ul style="list-style-type: none"> – Principles of psychiatric care in non-psychiatric settings and in the community – Resources available in the country concerned

Ethical and legal issues

This teaching should be integrated with the wider teaching of ethics within the Medical School.

Students are required to understand the principles involved in, and the practical consequences of:

- ◇ Informed consent and patients' rights
- ◇ Legal requirements for involuntary (compulsory) admission and/or treatment
- ◇ Confidentiality
- ◇ Issues related to the participation of patients in research
- ◇ The conflict between benefits and social justice

Appendix 3

Examples of student guidelines to the curriculum Submitted by the Department of Psychiatry, University of Pennsylvania

INTERVIEWING SKILLS

By the end of the clerkship, the student will conduct an interview in a manner that facilitates information-gathering and formation of a therapeutic alliance.

Specifically, the student will be able to:

1. explain the value of skilful interviewing for patient and doctor satisfaction and for obtaining optimal clinical outcomes;
2. demonstrate respect, empathy, responsiveness, and concern regardless of the patient's problems or personal characteristics;
3. identify his or her emotional responses to patients;
4. identify strengths and weaknesses in his or her interviewing skills;
5. discuss the above perceptions (Objectives 3 and 4) with a colleague or supervisor in order to improve interviewing skill;
6. identify verbal and non-verbal expressions of affect in a patient's responses, and apply this information in assessing and treating the patient;
7. state and use basic strategies for interviewing:
 - disorganized,
 - cognitively impaired,
 - hostile/resistant,
 - mistrustful,
 - circumstantial/hyperv verbal,
 - unspontaneous/hypoverbal,
 - and potentially assaultive patients;
8. demonstrate the following interviewing skills:
 - appropriate initiation of the interview;
 - establishing rapport;
 - appropriate use of open-ended and closed questions;
 - techniques for asking “difficult” questions;
 - appropriate use of facilitation, empathy, clarification, confrontation, reassurance, silence, and summary statements;
 - soliciting and acknowledging expression of the patient's ideas, concerns, questions, and feelings about the illness and its treatment;
 - communicating information to patients in a clear fashion;
 - appropriate closure of the interview;

9. state and avoid the following common mistakes in interviewing technique:

- interrupting the patient unnecessarily;
- asking long, complex questions;
- using jargon;
- asking questions in a manner suggesting the desired answer;
- asking questions in an interrogatory manner;
- ignoring patient verbal or non-verbal cues;
- making sudden inappropriate changes in topic;
- indicating patronizing or judgmental attitudes by verbal or non-verbal cues (e.g., calling an adult patient by his or her first name, questioning in an oversimplified manner, etc.);
- incomplete questioning about important topics;

10. demonstrate sensitivity to student-patient similarities and differences in gender, ethnic background, sexual orientation, socio-economic status, education, political views, and personality traits.

REFERENCES

Kaplan, Harold I. and Sadock, Benjamin J., *Comprehensive Textbook of Psychiatry*, 5th edition, Williams & Wilkins, Baltimore, 1989, pp. 1-13.

DELIRIUM, DEMENTIA, AND FOCAL BRAIN DISEASES

By the end of the clerkship, the student will recognise the psychiatric manifestations of brain disease of known aetiology or pathophysiology, and will state the evaluation and initial management of these neuropsychiatric disorders.

Specifically, the student will be able to:

1. recognise the cognitive, psychological, and behavioural manifestations of brain disease of known aetiology, anatomy, or pathophysiology;
2. define the terms delirium, dementia, treatable dementia, pseudodementia, cortical dementia, and subcortical dementia, and give examples of each;
3. state the features that distinguish dementia from pseudodementia;
4. discuss the clinical features and differential diagnosis of delirium;
5. discuss the behavioural and pharmacological treatments of delirious patients;
6. know the epidemiology, differential diagnosis, clinical features, and course of Alzheimer's disease, multi-infarct dementia, Parkinson's disease and HIV encephalopathy;
7. list the treatable causes of dementia, and summarise their clinical manifestations;
8. summarise the medical evaluation and clinical management of a patient with dementia;
9. employ cognitive screening evaluations to assess and follow patients with cognitive impairment, and state the limitations of these instruments;
10. state the neuropsychiatric manifestations of HIV related illnesses; and
11. state the neuropsychiatric manifestations of seizure disorders, strokes, and head injuries.

REFERENCES

Andreasen, Nancy C. and Black, Donald W., *Introductory Textbook of Psychiatry*, 2nd edition, American Psychiatric Press Inc., Washington, DC, 1995, pp. 139-155 and pp. 403-412.

Kaplan, Harold I. and Sadock, Benjamin J., *Comprehensive Textbook of Psychiatry*, 5th edition, Williams & Wilkins, Baltimore, 1989, pp. 241-269 and pp. 270-277.

MOOD DISORDERS

By the end of the clerkship, the student will recognise, evaluate, and state the treatments for patients with mood disorders.

Specifically, the student will be able to:

1. discuss neurobiological, genetic, psychological, and environmental hypotheses regarding the aetiology and pathophysiology of mood disorders;
2. state the epidemiological features, prevalence rates, and lifetime risks of mood disorders in clinical and non-clinical populations;
3. compare and contrast the epidemiological and clinical features of unipolar depression and bipolar disorder;
4. state the common signs and symptoms, differential diagnosis including the general medical illnesses that can present with depression, course of illness, co-morbidity, prognosis, and complications of mood disorders;
5. contrast normal mood variations, states of demoralisation, and bereavement with the pathological mood changes that constitute depressive disease;
6. identify the differences in the clinical presentation and treatment of depression with and without psychotic features;
7. identify the differences in the clinical presentation and treatment of depression with and without melancholic features;
8. define the term "atypical depression" and state what management is recommended;
9. compare and contrast the clinical presentations of mood disorders in children and adults;
10. describe some common presentations of depression in non-psychiatric settings, define the term "masked depression", and develop an approach to evaluating and treating affective disorders in a general medical practice;
11. outline the recommended acute and maintenance treatments for dysthymia, major depression, and bipolar disorder (manic and depressive phases);
12. state the characteristics and techniques of the non-pharmacological treatments for depression, including psychotherapy, cognitive therapy and couples therapy.

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

By the end of the clerkship, the student will demonstrate proficiency in the recognition, evaluation, and management of persons with psychosis associated with schizophrenic, affective, general medical, and other psychotic disorders.

Specifically, the student will be able to:

1. define the term psychosis;
2. develop a differential diagnosis for a person presenting with psychosis, including identifying historical and clinical features which assist in the differentiation of general medical, affective, schizophrenic and other causes;
3. state the neurobiological, genetic, and environmental theories of aetiology and pathophysiology of schizophrenia;
4. summarise the epidemiology, clinical features, course, and complications of schizophrenia;
5. name the clinical features of schizophrenia that are associated with good and poor outcome;
6. summarise the treatment of schizophrenia, including both pharmacological and psychosocial interventions;
7. list the features that differentiate delusional disorder, schizophreniform disorder, schizoaffective disorder, and brief reactive psychosis from each other and from schizophrenia.

REFERENCES

Andreasen, Nancy C. and Black, Donald W., *Introductory Textbook of Psychiatry*, 2nd edition, American Psychiatric Press Inc., Washington, DC, 1995, pp. 157-174 and pp. 175-187.

Kaplan, Harold I. and Sadock, Benjamin J., *Comprehensive Textbook of Psychiatry*, 5th edition, Williams & Wilkins, Baltimore, 1989, pp. 320-342 and pp. 343-362.

Appendix 4

ICD 10 Primary Care Version

Categories of mental and behavioural disorders

<u>Code</u>	<u>Disorder</u>
F00#	Dementia
F05	Delirium
F10	Alcohol use disorders
F11#	Drug use disorders
F17.1	Tobacco use disorders
F20#	Chronic psychotic disorders
F23	Acute psychotic disorders
F31	Bipolar disorder
F32#	Depression
F40	Phobic disorders
F41.0	Panic disorder
F41.1	Generalized anxiety
F41.2	Mixed anxiety and depression
F43.2	Adjustment disorder
F44	Dissociative (conversion) disorder
F45	Unexplained somatic complaints
F48.0	Neurasthenia
F50	Eating disorders
F51	Sleep problems
F52	Sexual disorders
F70	Mental retardation
F90	Hyperkinetic (attention deficit) disorder
F91#	Conduct disorder
F98.0	Enuresis
Z63	Bereavement disorders
F99	Mental Disorder, Not Otherwise Specified
U50#	Unused/temporarily unassigned to any category

Appendix 5

Methods of examination

A Guide for Selecting an Assessment Tool

TOOL	KNOWS	KNOWS HOW	SHOWS HOW	DOES
OBJECTIVE STRUCTURED CLINICAL EXAMINATION		2	1	
LOG BOOK		2	1	
IN TRAINING ASSESSMENT		2		1
STANDARDISED PATIENTS		2	1	
TRIPLE JUMP		2	1	
MINI CASES		2		
SHORT ANSWER QUESTIONS	1	1		
MULTIPLE CHOICE QUESTIONS	1	1		
EXTENDED MATCHING QUESTIONS	1	1		
MODIFIED ESSAY QUESTIONS	2	1		
LONG ESSAY	1	1		
MEDICAL RECORD REVIEW		2		1

KEY 1 = Most efficient use
2 = Secondary use

* Modified from: *State-of-the-Art Assessment in Medical Education* by Miriam Freedman, University of New Mexico, School of Medicine (1992)

For a more detailed description of the tools:

1. Assessment Handbook
Flinders University of South Australia
Graduate Medical School
GPO Box 2100
Adelaide, South Australia 5001

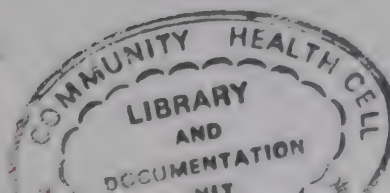
Prof. A. Crocker
Department of Clinical Pharmacology

Prof. J. Power
Department of Physiology

2. Student Assessment for Problem Based
and Inquiry Based Learning: A Workshop
Manual for Faculty Development

Grahaeme Feletti
Curriculum Coordinator
Ke Ola O Hawaii INC.

06117



Appendix 6

Annotated List of WHO Publications Relevant to the Teaching of Medical Students

Behavioural science learning modules

These short papers have been prepared to show how awareness of psychological factors can improve the conduct of medical procedures. They present good interviewing techniques and show how behavioural and cognitive principles can be put into practice. The following are all recommended:

(The documents are published in English only)

MNH/PSF/93.2A	Preparing Patients for Invasive Medical and Surgical Procedures: Behavioural and Cognitive Aspects
MNH/PSF/93.2B	Communicating Bad News
MNH/PSF/93.2C	Introducing Parents to their Abnormal Baby
MNH/PSF/93.2D	Promoting Nonpharmacologic Interventions to Treat Elevated Blood Pressure
MNH/PSF/93.2E	Psychological Interventions for Patients with Chronic Back Pain
MNH/PSF/93.2F	Self-Management of Recurrent Headache
MNH/PSF/93.2G	Improving Adherence Behaviour with Treatment Regimens
MNH/PSF/93.2H	Insomnia: Behavioural and Cognitive Interventions

Essential treatments in psychiatry

This is a series of documents summarising the treatments used in psychiatry. Sections may be useful in compiling course material for students. The first document is an overview, the others deal with specific methods. The four documents are:

MNH/MND/93.26	Essential Treatments in Psychiatry
MNH/MND/93.27	Essential Drugs in Psychiatry
MNH/MND/93.28	Essential Psychological Interventions in Psychiatry
MNH/MND/93.29	Essential Psychosocial Interventions in Psychiatry

Alzheimer's disease help for caregivers

This small paper is designed for caregivers but the practical advice that it contains could give students a clear idea of the problems faced by families and patients with this condition and the advice that is likely to be helpful for them.

Guidelines for the promotion of human rights for persons with mental disorders

This document is too detailed for directives for students but its systematic layout may be helpful to teachers preparing course material.

Appendix 7

Annotated Bibliography

Assessment of students

Examinations, the "tail that wags the dog" in medical education, consist traditionally of essays, practicals (laboratory or clinical), orals and, since the 60's multiple choice examinations. As long ago as 1924 a classical paper faulted examinations in higher education for lack of validity and reliability. They also foster rote learning and not deeper understanding of underlying principles, and develop the wrong learning

skills. They are commonly misused e.g. a multiple choice examination cannot possibly assess clinical skills, yet is widely used for the purpose. A range of different methods must be used to assess the range of knowledge, skills and attitudes being tested. New examinations in use include patient management problems, short answer questions, open book examinations, projects and longer dissertations.

REF: Newble D I, Jacger K (1983) The effects of assessments and examinations on the learning of medical students. *Medical Education* 17:165 - 171.

Formative assessment

Assessments taken by students during a course as an aid to learning, to obtain regular

feedback about progress and the extent to which they are meeting objectives.

Summative assessment

End-of-course examinations which either pass or fail candidates, in part a means for the institution regulate students' progression through the system and rank them in terms of

grades, and discard them if class size is excessive (as occurs in countries with *open entry* to medical school).

REF: Ende J (1983) Feedback in clinical medical education. *Journal of the Association of the American Medical Association* 250: 777-781

Communication Skills

These include basic medical interviewing skills, the ability to obtain informed consent, health education, motivation of the patient to be a partner in health care, health education, imparting bad news sensitively, handling complaints, and interprofessional

communication. Such teaching and learning throughout the curriculum addresses the professionally unacceptable fact that a main dissatisfaction of patients is the common inability of doctors to speak clearly with them about their and their relatives' illnesses.

World Health Organization (1993) *Doctor-Patient Interaction and Communication*. Geneva: WHO/MNH/PSF/P3,11.

Curriculum Committee

Set up by the Dean of the Medical Faculty, autonomous from departments and adequately resourced financially and secretarily, the Curriculum Committee needs to be independently responsible for educational matters in the medical school. Its membership is drawn from all the departments of the Faculty, but members then serve in their own capacity (not needing

to have decisions cleared by heads of departments, etc). The governance (i.e. committee structure of the medical school) may have to be changed to create these conditions, which are essential: much effort and innumerable attempts to reform curricula worldwide have failed because these administrative steps have been overlooked or shirked.

REF: Bloom SW (1989) The medical school as a social organization: the sources of resistance to change. *Medical Education* 23: 228-241.

Educational Objectives

Statement of the aims of a curriculum, course, teaching session, etc. in terms of what it is that the learner is expected to know

(knowledge), be able to do (skills), or be like (attitudes) at the end of the learning experience.

REF: Mager R F (1962) *Preparing Educational Objectives*. Palo Alto: Fearon Publishers Inc.

Electives:

For the designated period students pursue what interests them, with the approval of a responsible tutor. There is no reason why everybody has to study the same thing, as in the traditional curriculum. The *core plus options* model now operating in the UK aims at encouraging self-learning skills and at

reducing factual overload in the curriculum: two-thirds of the curriculum is a common *core*, which emphasizes discipline content, critical thinking, communication and interview skills; while one-third is left available for *special study modules* selected by the student from an array of options

available for *special study modules* selected by the student from an array of options available in the medical school, for indepth learning according to specific interests and needs. Electives may involve foreign travel,

but succeed best when the parent school and the host institution which the student visits for the clinical attachment confer responsibly.

REF: General Medical Council (1993) *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*. London: General Medical Council.

Macnaughton R J (1997) Special study modules: an opportunity not to be missed. *Medical Education* 31: 49-51.

Ethics

Ethical issues and moral challenges in medicine are no longer taught in a single course, but presented throughout the curriculum when dealing with the care of individual patients, public health services,

effect of poverty on health, allocation of health resources, formulation of health care policy, medical research, etc. and not overlooking the policy of the medical school and the conduct of its teachers.

REF: Siegler M, Pellegrino E D, Singer P A (1990) Clinical medical ethics. *Journal of Clinical Ethics* 1: 5-9.

Evaluation

Feedback about lectures, other teaching sessions, courses, curricula etc. to monitor and adjust and improve the learning experience for students, and provide feedback to teachers and the curriculum committee. Medical students play the crucial role; as the active recipients, they should be valued partners at every level, involved in

planning and evaluating their education, and students themselves should take seriously their potential to be agents for necessary educational change. External bodies may evaluate the medical schools (e.g. the GMC in the UK); or all the medical schools in a country may come together to arrive at verification of national standards.

REF: Cordova J A, guirre E, Hernandez A, Hidalgo V, Dominguez F, Durante I, Jesus R and Castillo O (1996) Assessment and accreditation of Mexican medical schools 30: 319-321.

Independent Learning

The activated medical student now required must be capable of self study and motivated for lifelong learning, therefore active methods of learning are now essential which include such student centred methods as

problem-solving, simulation and computer assisted learning, in place of passive methods emphasizing rote memorization of factual information.

REF: Towle A (1991) *Critical thinking: the future of undergraduate medical Education*. London: King's Fund Centre.

Information Overload

Curriculum overload is a fundamental and increasing problem with medical education, for which the traditional curriculum is notorious. Reform leads to three alternative *innovative* curricular models: 1. Integrated

curricula with systems teaching e.g. Cleveland, Newcastle etc; 2. Problem-based learning e.g. McMaster, Maastricht, etc. 3. Core-plus-options models, e.g. in the UK, at the University of Virginia etc.

REF: World Federation for Medical Education (1994) *Recommendations of the World Summit on Medical Education*. *Medical Education* 28, Suppl. 1.

Integrated Learning

Instead of the curriculum being divided according to disciplines or subjects (e.g. anatomy, cardiology, etc) as in the traditional curriculum with its preclinical and clinical sub-divisions, an *organ system* approach is adopted: everything about the cardiovascular system, as so also about all the other major systems, is taught together (e.g. cardiac embryology, anatomy, physiology,

pathology, heart disease, its epidemiology, prevention, etc, and teaching is arranged not by departments but by independent systems committees, on which relevant departments are of course represented. The Royal Commission on Medical Education laid down: "teaching time and the planning and conduct of the curriculum cannot any longer be left to individual heads of departments".

REF: *Report of the Royal Commission on Medical Education* (1968): London: Her Majesty's Stationery Office.

Objective Structured Clinical Examination (OSCE)

An examination method for assessing clinical skills, by setting up a series of "stations", at each of which the candidate is asked to perform a clinical task (e.g. test orientation for time and place, the examiner role-playing an Alzheimer patient), or

answer questions on material provided (interpretation of an EEG), or interact with a patient (e.g. an actor simulating alcoholism), while the examiner evaluates the performance using a standardized checklist.

REF: Harden RM, Gleeson FA (1979) Assessment of clinical competence using an objective structured clinical examination. *Medical Education* 13:41-54.

Problem-based learning

Students are presented with a real clinical problem e.g. breathlessness, fainting, chest pain, which they then use as a springboard to explore all related science or clinical aspects, working in groups with a non-directive tutor (facilitator). The emphasis is on active learning using a problem (e.g. hearing voices, over frequent handwashing, unusual

fatigue, etc) as a stimulus and a starting point for the learning process. The curricula of some medical schools are entirely problem-based e.g. McMaster, Harvard, Maastricht. Geziera (Egypt) etc. while at other schools only some disciplines or part-subjects are taught by this method.

REF: Walton H J, Matthews M B (1989) Essentials of problem-based learning. *Medical Education* 23:542-558.

Selection

The means whereby applicants to medical school are subjected to an admissions procedure (open entry systems now regarded as obsolete), with the screening procedure focused on:

- i. Intellectual ability (school-leaving examination performance);
- ii. Non-cognitive criteria (motivation, ability to communicate, social commitment, etc), often appraised by interview, and by scrutiny of the

applicant's description of special interests, voluntary work, and other biographical information. Screening inventories are used in some countries e.g. *the Medical College Admissions Test (MCAT)* in the US; research enquiries (which every medical school should conduct into its own selection procedure) often include psychological tests.

REF: World Federation for Medical Education (1988). The Edinburgh Declaration, principle 8. *The Lancet* ii:464.

Simulated patients

Healthy people (e.g. actors, housewives, recovered patients, etc.) are trained to present clinical problems to students, for use in practice of history taking, clinical examination, getting consent for operation,

breaking bad news, etc. When intensively trained, simulated patients can give convincing presentations of a specific medical condition, and can also be trained to give feedback to students.

REF: Stillman P, Wang Y, Ouyang Q, Zhang S, Yang Y, Sawyer W D (1997) Teaching and assessing clinical skills: a competency-based programme in China. *Medical Education* 31:33-40.

Small group methods

The teaching skills needed to conduct tutorial teaching, seminars, group sessions in problem-based learning, or any other learning activity promoting interaction among a group of student. Leaders of

tutorials or facilitators in problem based learning need to know about group dynamics, and understand the phases through which any group will pass during a series of meetings.

REFS: Walton H J (1997) Small group methods. *Medical Education* 31, September issue.

Westberg J, Jason H (1996) *Fostering Learning in Small Groups*. New York: Springer Publishing Co. Ltd.

Teacher Development

Provision of teaching skills to medical school staff, who almost always have been appointed for research expertise or clinical excellence, and as far the important educational part of their job is concerned are amateurs, and few receive any training in

educational method. The need now for activated medical students requires medical school staff to have a more professional attitude to teaching; teaching excellence must be rewarded and staff or units penalized if teaching obligations are not fulfilled.

REF: Coles C, Holm HA (1994) *Learning in Medicine*. Oxford: Oxford University Press.
Olmesdahl P J (1997) Rewards for teaching excellence: practice in South African medical schools. *Medical Education* 31, 27-32.

Appendix 8

Addresses

Further information and relevant documents may be obtained from:

1. World Psychiatric Association (WPA)

Address: International Center for Mental Health
Mount Sinai School of Medicine of the
City University of New York
Fifth Avenue & 100th Street, Box 1093 New York
New York 10029-6574, U.S.A.

Tel: (1-212) 241-6133 or (1-718) 334-5094
Fax: (1-212) 426-0437 or (1-718) 334-5096

2. World Federation For Medical Education (WFME)

Address: The University of Edinburgh
Centre for Medical Education
38 Blacket Place
Edinburgh, EH9 1RL
Scotland

Tel: (0) 131-667 7811
Fax: (0) 131-662 0337

3. World Health Organisation (WHO)

Address: Division of Mental Health and
Prevention of Substance Abuse
CH 1211, Geneva
27-Switzerland

Tel: (41) 22 791 3617
Fax: (41) 22 791 0746

